

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:  
03-11

2. STATE  
Nevada

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE  
September 1, 2003

5. TYPE OF PLAN MATERIAL (*Check One*):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.40

7. FEDERAL BUDGET IMPACT:

a. FFY 2004 \$ None

b. FFY 2005 \$ None

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19C, page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (*If Applicable*):

Attachment 4.19C, page 1

10. SUBJECT OF AMENDMENT: Policy change that will simplify and improve the procedure and tracking mechanism for facilities (IMD, NF, SNF, ICF, ICF/MR) whose patients utilize therapeutic leave days for which Medicaid reimbursement is available.

11. GOVERNOR'S REVIEW (*Check One*):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Michael J. Willden

14. TITLE:

Director, DHR

15. DATE SUBMITTED:

16. RETURN TO:

John A. Liveratti, Chief  
DHCFP/Medicaid  
1100 East William Street, Suite 102  
Carson City, Nevada 89701

## FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

July 18, 2003

18. DATE APPROVED:

December 5, 2003

19. EFFECTIVE DATE OF APPROVED MATERIAL:

September 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Linda Minamino

22. TITLE: Associate Regional Administrator  
Division of Medicaid & Children's Health

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nevada

Attachment 4.19-C  
Page 1

PAYMENT FOR RESERVED BEDS FOR THERAPEUTIC LEAVE OF ABSENCE

1. Payment for reserved beds will not be made in an acute care facility.
2. Payment for therapeutic leave of absence, or reserved beds, may be made in an institution for mental diseases (IMD), a skilled nursing facility (SNF), a nursing facility (NF), an intermediate care facility (ICF), or an ICF for the mentally retarded (ICF/MR), subject to the following conditions:
  - a. The purpose of the therapeutic leave of absence is for rehabilitative home and community visits including preparation for discharge to community living;
  - b. The patient's attending physician authorizes the therapeutic leave of absence and the plan of care provides for such absences;
  - c. An IMD, SNF, NF, ICF, or ICF/MR will be reimbursed their per diem rate for reserving beds for Medicaid recipients who are absent from the facility on therapeutic leave up to a maximum of twenty-four (24) days annually. For this purpose, annually is defined as a calendar year beginning on January 1 and ending on December 31 of the same year.

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TN# 03-11  
Supersedes  
TN# 84-09

Approval Date DEC - 5 2003 Effective Date 09/01/03